

BUREAU OF HEALTH PROFESSIONS

**PRIVACY ACT RELEASE
AUTHORIZATION**

I, _____, residing at _____,
_____, hereby authorize the Department of Health
and Human Services (DHHS) to disclose any information contained in its files relating to
my participation in the National Health Service Corps Scholarship Program (Section
751/338A, PHS Act)

To _____ of _____
(Name of the Firm/Individual) (Relationship)

(Address)

This authority shall remain in effect until I notify you otherwise in writing.

(Signature of Participant) (Date)

I certify that I am the above named participant. I understand that the knowing and willful
request for, or acquisition of, information pertaining to an individual from an agency under
false pretenses is a criminal offense under the Privacy Act, subject to a \$5,000.00 fine
(5 U.S.C. 552a(i)(3)).

(Signature of Participant) (Date)

(Social Security Number)

Return to: Division of National Health Service Corps
In-School/In-Training Branch
4350 East West Highway, 10th Floor
Bethesda, Maryland 20814